41

HOUSTON COUNTY JAIL
NURSING DEPARTMENT
FLOW SHEET

NAME: Rhodes, George D.O.B. 4-6-65 I/M # 57322

MEDICATIONS:

6/15/05	1. Atenolol 25mg PO daily	cont
↓	2. ASA 81mg PO daily	↓
2/22/06	3. IBU 600mg PO bid x 10days then ↓ 400 bid x 20d	3/24
↓	4. Flexeril 10mg PO bid x 30 days	↓
4/4/06	5. Flexeril 10mg po bid x30 days	5/5
5/11/06	6. Ultram 100mg po tid x 30d	
↓	7. Tylenol 1gm. po tid x 30d	
	8.	
	9.	
	10.	

CLINIC'S:

HIV

COPD

SEIZURE

DIABETIC

HEPATITIS

HYPERTENSION ✓

LAB:

		NURSE SIG.
DATE 4/4/06	XRay (R) femur	w/ calcification in soft tissue
DATE 5/1/06	MRI - (R) mass	? Chondrosarcoma ? osteogenic sarcoma
DATE		
DATE		
DATE		
DATE		
DATE		
DATE		

MISCELLANEOUS:

1/05: Normal GXT
Normal LV funct
9/9/05 116/81
PmH: palpitation
11-4-05 - HR = 68
7/14/05 Xray (R) femur -> indeterminate calcification in soft tissue (R) thigh

6/20/06 - 0830 c̄ Dr. Seagle - UAB, (205) 975-0415 (Michelle Gray NP)

PROBLEMS:

DATE

DATE

DATE

DATE

DATE

Pg. # DIABETIC FLOW SHEET BP FLOW SHEET

4/25/06 - MRI - (R) upper femur - rescheduled to 4/28/06 @ 0645 - rescheduled 2° equip failure - Sched for 5/2/06
5/2/06 (appt rescheduled 2° I/M in court) - 5/10/06 - MRI
5/15/06 - Appt @ SB+J

HOUSTON COUNTY JAIL
NURSING DEPARTMENT
LAMAR GLOVER , SHERIFF

HYPERTENSION CLINIC

B/M Food

BLOOD PRESSURE FLOW SHEET:

NAME Rhodes, George D.O.B. 4-6-65 I/M # 57322

DATE	BP	WT	DATE	BP	WT	DATE	BP	WT
10-17-05	115/77							
11-4-05	HR = 68							
12-9-05	127/90							
Rev	128/89							
2-10-06	117/75							
4-4-06	131/90 129/90							
2/22/06	119/79, 60							
9/9/05	116/81							
~~10/19/05~~								
5/3/06	115/77 HR92							

Other Disease's:

HOUSTON COUNTY JAIL
RECEIVING SCREENING FORM

F-FIR 98?

NAME: Rhodes, George RACE/SEX: B/m D.O.B: 4/6/65

DATE: 4/29/05 TIME: _____ DOCTOR: _____

BOOKING OFFICER: D Mills MEDICAL INSURANCE: _____

SOCIAL SECURITY NUMBER: 136 - 60 - 1743 INMATE NUMBER: 57322

VISUAL OPTION:

1. IS THE PERSON CONSCIOUS?	(YES)	NO
2. IS THERE PAIN OR OTHER SYMPTOMS OF NEED FOR EMERGENCY MEDICAL TREATMENT?	YES	(NO)
3. IS THERE OBVIOUS FEVER OR OTHER EVIDENCE OF INFECTION WHICH MIGHT SPREAD?	YES	(NO)
4. IS THE SKIN IN GOOD CONDITION AND FREE OF VERMIN?	(YES)	NO
5. DOES HE/SHE APPEAR TO BE UNDER THE INFLUENCE OF ALCOHOL OR DRUGS?	YES	(NO)
6. ARE THER ANY VISIBLE SIGNS OF ALCOHOL/DRUG WITHDRAWAL SYMPTONS?	YES	(NO)
7. DOES HE/SHE BEHAVE ABNORMALLY? EXPLAIN _____	YES	(NO)
8. DOES THE INMATES BEHAVIOR SUGGEST THE RISK OF ASSAULT TO STAFF OR OTHERS?	YES	(NO)
9. DOES THE INMATE HAVE A MEDICAL ALERT CARD OR OTHER MEDICAL INFORMATION?	YES	(NO)

OFFICIAL – INMATE QUESTIONNAIRE:

10. ARE YOU TAKING MEDICATION FOR DIABETES, HEART DISEASE, SEIZURES, ARTHRITIS, ASTHMA, ULCERS, HIGH BLOOD PRESSURE, OR PSYCHIATRIC DISORDER? (CIRCLE WHICH).	YES	NO
11. DO YOU HAVE MEDICATION WITH YOU?	YES	(NO)
12. DO YOU HAVE A HISTORY OF TUBERCULOSIS?	YES	(NO)
13. DO YOU HAVE A HISTORY OF VENEREAL DISEASE OR ABNORMAL DISCHARGE?	YES	(NO)
14. HAVE YOU RECENTLY BEEN HOSPITALIZED OR RECENTLY SEEN A DOCTOR FOR ANY REASON? IF YES; EXPLAIN: _____	YES	(NO)
15. ARE YOU ALLERGIC TO ANY MEDICATION? WHAT? _____	YES	(NO)
16. HAVE YOU FAINTED RECENTLY OR HAD A HEAD INJURY?	YES	(NO)
17. DO YOU HAVE EPILEPSY, DIABETES, HEPATITIS, OR ANY CHRONIC ILLNESS? _____	YES	(NO)
18. DO YOU HAVE A PAINFUL, DENTAL CONDITION?	YES	(NO)
19. IF FEMALE, ARE YOU PREGNANT? ON BIRTH CONTROL PILLS? (CIRCLE WHICH)	YES	(NO)
20. DO YOU HAVE A SPECIAL DIET PRESCRIBED BY A PHYSICIAN? TYPE _____	YES	(NO)
21. DO YOU HAVE ANY OTHER MEDICAL PROBLEM WE SHOULD KNOW ABOUT? REMARKS: _____	YES	(NO)

HOUSTON COUNTY JAIL
JAIL DOCKET CARD

1515

INMATE #	LAST NAME	FIRST	MIDDLE	MAIDEN	ALIAS	VICTIM NOTIFICATION
57322	Rhodes	George	"NMN"	Henry		

ARRESTING AGENCY	DATE RECEIVED	TEMP RELEASE DATE	RETURN DATE	RELEASE DATE	HOW RELEASED
DPD	4/29/05				

RISK	STATUS	FLOOR	CELL	DOCKET OFFICER	ARRESTING OFFICER
		F	F1R	Miller	B. Bailey

AGE	DOB	SSN	RACE	SEX	HEIGHT	WEIGHT	HAIR	EYES	AGENCY HOUSED FOR
	4/6/65	136-60-1743	B	M	5'9"	165	Blk	Bro	Houston

ENTRANCE NCIC/BY	ENTRANCE HOUSTON/BY	ENTRANCE DPD/BY	FELONY CRIMINAL HISTORY/BY
Neg C-12	NEG J48	Neg came from	

EXIT NCIC/BY	EXIT HOUSTON/BY	EXIT DPD/BY	ATTORNEY
			Joe Herring

HOLD 1	DATE/BY	HOLD RELEASE DATE/BY	HOLD 2	DATE/BY	HOLD RELEASE DATE/BY

HOLD 3	DATE/BY	HOLD RELEASE DATE/BY	HOLD 4	DATE/BY	HOLD RELEASE DATE/BY

ADDRESS	CITY	STATE	PROBATION/PAROLE OFFICER
507 S Ussery St 794 3424	Dothan	AL	

NEXT OF KIN	ADDRESS	CITY/STATE	PHONE	RELATION
Keesha Rhodes	Same			Sister

REMARKS:

DID INMATE RECEIVE PHONE CALL? { }Y { }N	DID INMATE RECEIVE JAIL RULES? { }Y { }N
INMATE SIGNATURE: X George Rhodes	INMATE SIGNATURE: X George Rhodes

SOUTHEASTERN PRINTERS OF DOTHAN / FORM HCJDC 334-792-2928

INMATE#	NAME					
57322	Rhodes, George					
CHARGE	WARRANT #	DC/TR	INDICTMENT#	CC/CS/DR	CONVICTION	
Burglary 3rd	05-13987	05-1709	296			
BOND						
10,000	06-01-05 @ 8:30 for Prel. Hrng. 5-18-05 8:30 AM 06/13- Motion to reduce denied. 07/07/05 AAG Trial 10-28-06					

CHARGE	WARRANT #	DC/TR	INDICTMENT#	CC/CS/DR	CONVICTION
BOND					

CHARGE	WARRANT #	DC/TR	INDICTMENT#	CC/CS/DR	CONVICTION
BOND					

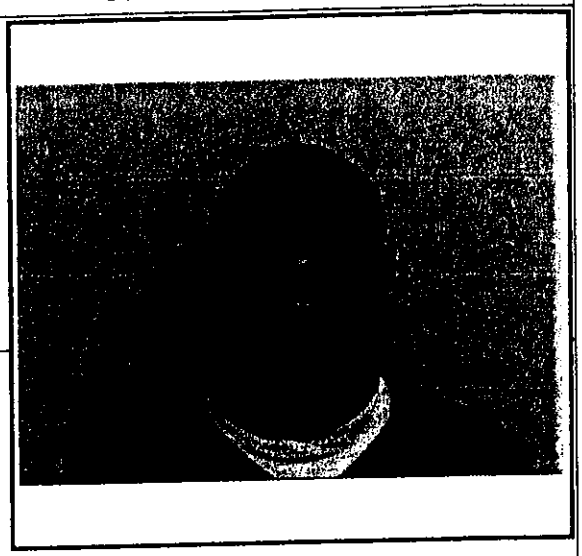
CHARGE	WARRANT #	DC/TR	INDICTMENT#	CC/CS/DR	CONVICTION
BOND					

CHARGE	WARRANT #	DC/TR	INDICTMENT#	CC/CS/DR	CONVICTION
BOND					

HOUSTON COUNTY SHERIFFS OFFICE

INMATE INFORMATION SHEET

BOOKING NO: 050001725 LOCAL ID: 57322



Name : RHODES GEORGE "NMN"

Address: 507 S. USSERY ST

City : DOTHAN State: AL Zip: 36303

Physical Description

Race : BLACK

Gender: MALE

Height: 5 ' 09 "

Weight: 165

Scars/Tattoos:

Hair : BLACK

Eyes: BROWN

Complexion: UNKNOWN

DOB: 04/06/1965 Age: 40

Personal Information

DL State :

DL Number:

SSN: 136 60 1743

SID:

Home Phone: 334 794 5424

Work Phone: 334 699 1820

Booking Information

Arrest Date: 04/29/2005

Arrest Dept: DPD

Arrest Offcr: BAXLEY

Search Offcr:

Meal Code: 01

Booking Officer: TJACKSON

Booking Date: 04/29/2005

Booking Time: 23:46

Facility: 01

Cell Assignment: F-FLR

Charge Information

Offense	Fine	Bond	Disposition
BURG III	$00.00	$10,000	PENDING

HOUSTON COUNTY JAIL
RECEIPT OF ARMBAND

I Rhodes, George have received an armband from Houston County Jail. I must wear this armband at all times while incarcerated in the Houston County Jail. I understand that I must have the armband on to receive medication, commissary, mail or any other items from the jail staff. If I am caught with out my armband I will receive a sanction. I must turn in this armband upon release from the jail. I can not give this armband to any other inmate.

George Rhodes
Inmate Signature

6/18/05
Date

K. Barnes
C/O Signature

6/17/05
Date

HOUSTON COUNTY JAIL
BOOKING CHECK OFF LIST

DATE: 4/29/05 TIME: _____

SENIOR CORRECTIONS OFFICER(S) DUTY Bonin

Inmate Name: Rhodes, George Inmate Number: 57322

BOOKING OFFICER MUST INITIAL AFTER COMPLETING EACH ITEM AND SIGN IN THE PROPER SPACE.

PM 1. All personal property secured
___ 2. Check in-house warrants
___ 3. Check for last incarceration
___ 4. Arrest report completed by arresting officer
___ 5. All charges listed on arrest report and bonds listed for each charge
___ 6. **Bond amount noted on warrant**
___ 7. All inmate property tagged/placed in envelope
___ 8. Property envelope completely filled out/signed by inmate
___ 9. All money counted/logged in money book
___ 10. Money envelope completed/supervisor counts
___ 11. SCO calls control and logs money in SCO money book
___ 12. SCO seals money/places in box
___ 13. **Check for outstanding warrants_____NCIC_____Dothan**
___ 14. Inmate numbers properly assigned
___ 15. Inmate recorded in black book
___ 16. Inmate recorded on white pages
___ 17. **Docket I.D., floor card completed, and bond amount verified on docket card**
___ 18. Fingerprint card completed
___ 19. Medical screen completed
___ 20. Affidavit of hardship completed
___ 21. Green disposition form completed (FBI)
___ 22. Property hold form (telephone call, bond applied)
___ 23. Fingerprinted/photographed/entered in computer
___ 24. Property card completed
___ 25. Visitor/Telephone list completed
___ 26. Inmate handbook received
___ 27. **Bond completed/amount checked against warrant**
___ 28. **Correct court date noted on bond**
___ 29. **Inmate and surety signature on bond**
___ 30. **All pass on information documented in pass book**

P Mello

Signature of Booking Officer(s)

Southeastern Printers of Dothan, 334-792-2928

Houston County Jail Medical Clinic
901 East Main Street
Dothan, Alabama 36301

Fax Transmittal

Phone: (334) 712-0762
Fax: (334) 671-9482

Lamar Glover, Sheriff

Dr. Sam Banner, Medical Director

Darla Speigner CRNP, Clinical Director

To: SAMC — Outpatient

Dr: _____

Department: Medical Records

Inmate Name:	DOB	SS#
Rhodes, George	4-6-65	416-72-9316

Please Send The Requested:

- ☐ Medical Records
- ☐ ~~Medical Diagnosis~~
- ☐ Other _____
- ☐ Medical Administration Record
- ☐ ~~X-ray Reports~~
- ☐ Specified Dates _____

Thanks for your Cooperation

Houston County Nursing Department

Faxed 4-5-06

Southeast Alabama
MEDICAL CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: Rhodes, George Date of Birth: 4-6-65

Address: _____

_____

Social Security #: _____ Telephone: _____

Information To Be Released - Covering the Periods of Health Care

From (date) April 4, 2006 to (date) present

From (date) _____ to (date) _____

Please check type of information to be released:

- ☐ Complete health record
- ☐ Complete billing record
- ☐ Consultation reports
- ☐ Discharge summary
- ☐ Emergency Dept. Reports
- ☒ Face Sheet
- ☐ History and physical exam
- ☐ Itemized bill
- ☐ Laboratory test results
- ☐ Pathology Report
- ☐ X-ray films / images
- ☒ X-ray reports
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Other, (specify) Outpatient on 4-4-06

Purpose of Request

- ☐ Treatment or consultation
- ☐ At the request of the patient
- ☐ Billing or claims payment
- ☐ Other, (specify) _____

Who and Where to Send / Release Information

Name: _____

Address: _____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Circle One: (Yes) No

I understand if my medical or billing records or psychotherapy notes contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.

Circle One: (Yes) No

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Medical Records Manager at Southeast Alabama Medical Center, P. O. Box 6987, Dothan, AL 36302. Unless revoked, this authorization will expire on the following date or event _____, or 180 days from date of signature, unless otherwise specified.

Southeast Alabama
MEDICAL CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. SOUTHEAST ALABAMA MEDICAL CENTER, ITS AFFILIATES, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that my treatment or payment for services will not be denied if I do not sign this authorization unless specified on the other side of this form under Purpose of Request. I can inspect or receive a copy of the protected health information to be used or disclosed. I understand that there may be a charge for copies.
I authorize SOUTHEAST ALABAMA MEDICAL CENTER to use and disclose the protected health information specified on the other side of this form.

George H. Rhodes, Jr. — Signature of Patient or Personal Representative

4-5-06 — Date

Relationship if not patient: (Guardian/Executor of Estate/Personal Representative)

Day time phone number

Witness: _____

For Southeast Alabama Medical Center Use Only:

Patient's Medical Record #_____ Account #_____

Check Records Received by Patient:

☐ Complete health record	☐ Face Sheet	☐ X-ray films / images
☐ Complete billing record	☐ History and physical exam	☐ X-ray reports
☐ Consultation reports	☐ Itemized bill	☐ _____
☐ Discharge summary	☐ Laboratory test results	☐ _____
☐ Emergency Dept. Reports	☐ Pathology Report	☐ _____

☐ OTHER _____

TOTAL PAGES SENT/GIVEN:_____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

_____

Verified by: _____

TELEPHONE FOR MEDICAL RECORDS: (334) 793-8864

SOUTHEAST ALABAMA MEDICAL CENTER

Physician's Order

PHYSICIAN ORDERS

INMATE: Rhodes, George

DATE: 6/15/06

CT scan of head & chest with & without contrast;

Dx: Rule out metastatic carcinoma

R. Spurgin CRNP/Dr. Bonner

please send results on disc & paper for referral to UAB ASAP

Thanks
ds

6/15/06 Please reschedule the CT scan

HOUSTON COUNTY JAIL
INFIRMARY

SICK CALL

D. SPEIGNER CRNP DR. SAM DANNER

DATE 5-11-06

Inmate Rhodes, George D.O.B. 4-6-65 HM# 57322

Chief Complaint MRI - Results

Allergies NKDA

V/S 133/86 92 18 98.2 Re 90

Wt. 165

02=98%

Discussed MRI reports - have referred to orthop. surgeon

Ultram 100 mg p.o. tid x 30 d. prn
Tylenol 1gm p.o. tid

CSV
FSV
CTV
MARV

SOUTHEAST ALABAMA MEDICAL CENTER

PO Drawer 6987, Dothan, AL 36302
334-793-8111

RADIOLOGY SERVICES

MRI REPORT

Patient Name: RHODES, GEORGE
XRAY/MR#: 000400545
DOB: 04/06/1965
Order #: 00127777888379206
CDM: 3836172

Account #: 2777788
Age: 41
Accession #: 001000000154472

Room:MI- -
Pt Type: O

Attending Physician: Sam Banner, MD
Ordering Physician: Sam Banner, MD
Referring Physician: Sam Banner, MD
Exam Requested: MRI LOW EXT WO/W RT
Exam Date: 05/10/2006

PROCEDURE: MR RIGHT FEMUR W/O AND W/GADOLINIUM
HISTORY: RIGHT HIP PAIN AND SWELLING SINCE 2/11/06. PATIENT FELL AND HURT RIGHT HIP ON 2/11/06.
COMPARISON: PLAIN RADIOGRAPHS 4/4/06
TECHNIQUE: PATIENT STUDIED WITH AXIAL, CORONAL AND SAGITTAL T1 AND STIR SEQUENCES. IN ADDITION POST GADOLINIUM FAT SUPPRESSED CORONAL AND AXIAL T1 WEIGHTED SEQUENCES PERFORMED.

FINDINGS:
There is a large mass-like area involving the right upper thigh which is slightly hyperintense to muscle on T1 and is markedly hyperintense on T2 and has internal areas of mixed signal. Associated with this is abnormal marrow signal in the region of the greater trochanter of the femur and extending slightly into the intertrochanteric area. Review of the plain x-ray from 4/4 shows some soft tissue calcification. Following Gadolinium administration there is abnormal enhancement evident within the periphery of the soft tissue of the mass as well as some abnormal enhancement within the intertrochanteric portion of the femur itself.

Continued..

SOUTHEAST ALABAMA MEDICAL CENTER
PO Drawer 6987, Dothan, AL 36302
334-793-8111

The mass-like area mainly is involving the area of the vastus lateralis but near the upper thigh is almost completely encircling the femoral shaft. Main considerations particularly given the history of pain the abnormal soft tissue calcification and the appearance of the mass with the abnormal Gadolinium enhancement is that of some type of chondrosarcoma. Other considerations include osteogenic sarcoma or much less likely a stress fracture of the femur with associated myositis ossificans. Patient incidentally appears to have some small inguinal lymph nodes bilaterally.

IMPRESSION:

1) LARGE MASS MEASURING APPROXIMATELY 13 X 9 X 8.5cm WHICH HAS ASSOCIATED SURROUNDING EDEMA IN THE SOFT TISSUES OF THE THIGH AS WELL AS ABNORMAL MARROW SIGNAL IN THE GREATER TROCHANTERIC REGION OF THE FEMUR. THIS IS SUSPICIOUS FOR ENTITIES SUCH AS A CHONDROSARCOMA, OSTEOGENIC SARCOMA OR LESS LIKELY A MALIGNANT FIBRO-CYSTICOTOMY. STRESS INJURY TO THE FEMUR WITH ASSOCIATED MYOSITIS OSSIFICANS MIGHT POSSIBLY GIVE THIS APPEARANCE BUT IS FELT LESS LIKELY GIVEN THE MARKEDLY ABNORMAL ENHANCEMENT PATTERN IN THE PROXIMAL FEMUR.

Hugh Holloway, MD

DD: 5/10/2006 13:02 dm
DT: 5/10/2006 16:11 147847

Name: RHODES, GEORGE MR: 000400545
Hugh Holloway, MD

COPY FOR Sam Banner, MD

HOUSTON COUNTY JAIL
INFIRMARY
901 EAST MAIN STREET
DOTHAN, ALABAMA 36301

SECTION 1 TO BE COMPLETED BY CORRECTIONAL FACILITY

Inmate referred to : (Name & Address) Dr. Choquette SB&J on the Circle	Reason for referral: MRI results from 5/10/06 reveal osteogenic sarcoma

Appointment Date	Appointment Time	Date of Birth	Social Security #
5/15/06	0800 (8 a.m)	4-6-65	136 60 1743

Inmates Name: Rhodes, George	Additional Health Info. : Atenolol 25mg po daily ASA 81mg po daily

Sgt Reynolds 05-11-06

Reason for Referral :

Appr'd by Dr. B.

Deputy Required yes ( ) No (✓)   Ambulance Required Yes ( ) No (✓)

Nurse : RN or L. Lazenby LPN

SECTION 2 TO BE COMPLETED BY INMATE

I authorize release of medical information to the Houston County Sheriff's Department.

Signature of Inmate ______ Date : ______

SECTION 3 TO BE COMPLETED BY PROVIDER

( ) Treated   ( ) Further follow-up needed   ( ) REFER for another Treatment or Test

DIAGNOSIS:	TREATMENT :

SIGNATURE OF PROVIDER ______ DATE ______

CLINIC DIRECTOR :
D. Speigner CRNP

Telephones : (334) 712-0762 ext. 120 or 122
Sheriff's Office (334) 677-4888

9-20

Dgt Driver 5-2-06

HOUSTON COUNTY JAIL
INFIRMARY
901 EAST MAIN STREET
DOTHAN, ALABAMA 36301

SECTION 1 TO BE COMPLETED BY CORRECTIONAL FACILITY

Inmate referred to : (Name & Address)	Reason for referral:
SAMC - Outpatient admitting for "MRI"	Md order

Appointment Date	Appointment Time	Date of Birth	Social Security #
5-10-06	930AM	4/6/65	136-60-1943

Inmates Name:	Additional Health Info. :
Rhodes George	

Reason for Referral :

Deputy Required yes ( ) No (X) **Ambulance Required Yes ( ) No (X)**

Nurse : RN or L. Laguerre LPN

SECTION 2 TO BE COMPLETED BY INMATE

I authorize release of medical information to the Houston County Sheriff's Department.

George K. Rhodes, Jr. Date : 5-10-06

Signature of Inmate

SECTION 3 TO BE COMPLETED BY PROVIDER

( ) Treated ( ) Further follow -up needed ( ) REFER for another Treatment or Test

DIAGNOSIS:	TREATMENT :

SIGNATURE OF PROVIDER DATE

CLINIC DIRECTOR :
D. Speigner CRNP

Telephones : (334) 712-0762 ext. 120 or 122
Sheriff's Office (334) 677- 4888

√CS

Wednesday 5/10/06 930 AM

HOUSTON COUNTY JAIL
INFIRMARY

SICK CALL

D. SPEIGNER CRNP DR. SAM DANNER

DATE 5-10-06

Inmate Rhodes, George D.O.B. 4-6-65 IM# 57322

Chief Complaint _____

Allergies [redacted] V/S 120/88 93 18 98.2

Wt. 166

- States on Monday, while sitting down, he developed sharp, constant pains down posterior Ⓡ upper leg & anterior Ⓡ lower leg. States the pain lasted from 1300-1325 & was afraid to bend his knee then 2° pain. C/o limited ROM in Ⓡ thigh area/joint. Denies any further occurrences such as this.
- Ⓡ upper thigh still noted to have an area of swelling. - Still measures 61cm.

NAD.
Pedal pulses palp/equal bilat

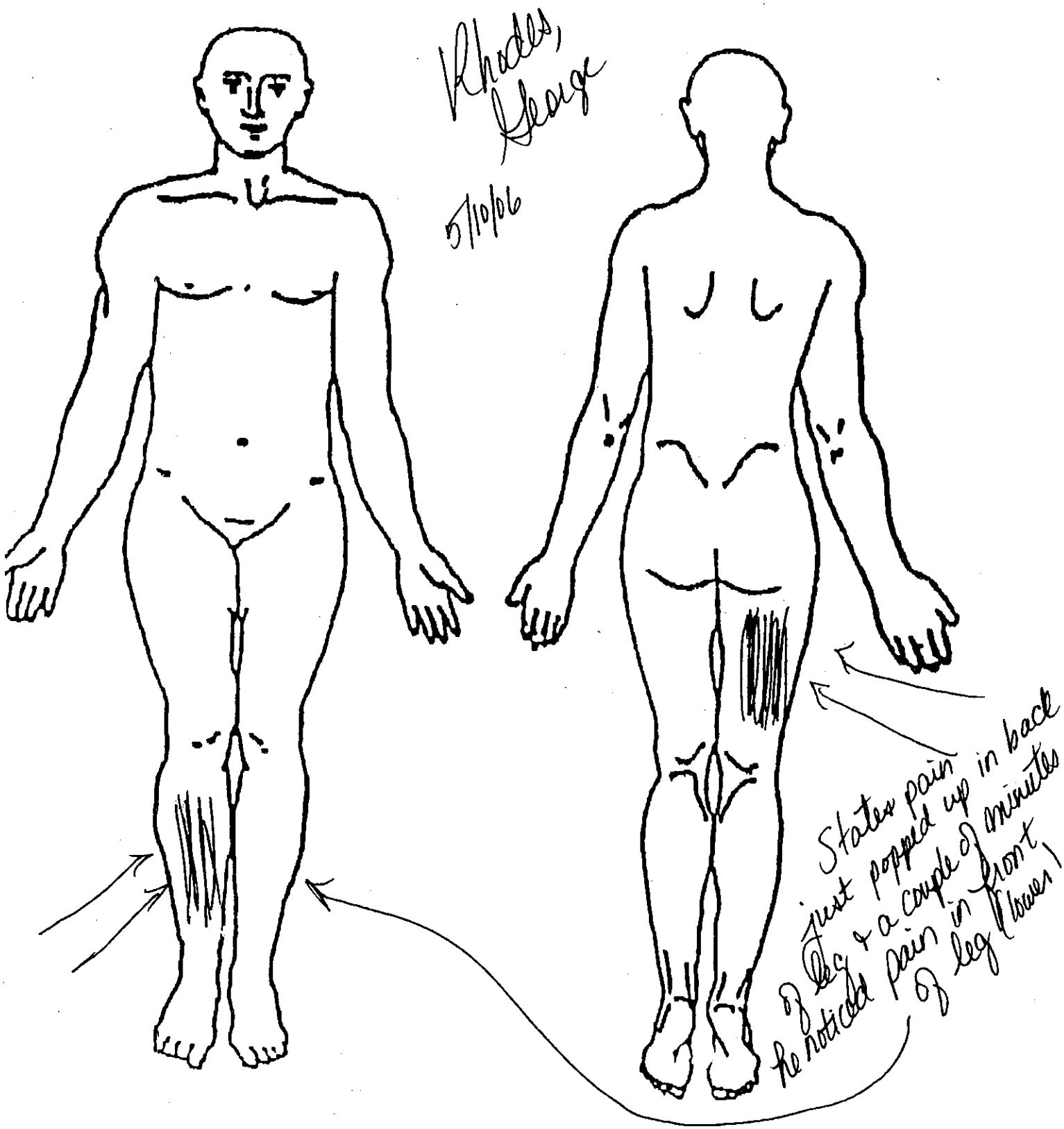
- R/o
- Muscle Rub (per Pt request)
Refer

went for MRI F/U visit
Waiting for MRI results

CSV

to Dr Bass 5/11/06

SDJ 5/15/06


Rhodes, George
5/10/06
States pain just popped up in back of leg & a couple of minutes he noticed pain in front of leg (lower)

PHYSICIAN ORDERS

INMATE: Rhodes, George #57322

DATE: 5/10/06

MRI results discussed w Dr. Barron

Plan - 1. Schedule F/u to see Dr. Barron tomorrow done

2. Schedule referral to Southern Bone & Joint 793-2663
Dana
next week for osteogenic sarcoma

LPN
to
go c
F/u

Houston County Jail Medical Clinic
901 East Main Street
Dothan, Alabama 36301

Fax Transmittal

Phone: (334) 712-0762
Fax: (334) 671-9482

Lamar Glover, Sheriff

Dr. Sam Banner, Medical Director

Darla Speigner CRNP, Clinical Director

To: SAMC – outpatient

Dr: _____

Department: Medical

Inmate Name:	DOB	SS#
Rhodes, George	4-6-65	136-60-4317

Please Send The Requested:

- ☐ Medical Records
- ☐ Medical Diagnosis
- ☐ Other _____
- ☐ Medical Administration Record
- ☐ X-ray Reports
- ☐ Specified Dates _____

MRI – Results

Thanks for your Cooperation

Houston County Nursing Department

asap please

Southeast Alabama
MEDICAL CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: Rhodes, George Date of Birth: 4-6-65

Address: _____

_____

Social Security #: 136-60-4317 Telephone: _____

Information To Be Released - Covering the Periods of Health Care

From (date) May 10, 2006 to (date) —

From (date) _____ to (date) _____

Please check type of information to be released:

- ☐ Complete health record
- ☐ Complete billing record
- ☐ Consultation reports
- ☐ Discharge summary
- ☐ Emergency Dept. Reports
- ☐ Face Sheet
- ☐ History and physical exam
- ☐ Itemized bill
- ☐ Laboratory test results
- ☐ Pathology Report
- ☐ X-ray films / Images
- ☐ X-ray reports
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Other, (specify) _____

Purpose of Request

- ☐ Treatment or consultation
- ☐ At the request of the patient
- ☐ Billing or claims payment
- ☐ Other, (specify) _____

Who and Where to Send / Release Information

Name: _____

Address: _____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Circle One: (Yes) No

I understand if my medical or billing records or psychotherapy notes contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.

Circle One: (Yes) No

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Medical Records Manager at Southeast Alabama Medical Center, P. O. Box 6987, Dothan, AL 36302. Unless revoked, this authorization will expire on the following date or event _____, or 180 days from date of signature, unless otherwise specified.

Southeast Alabama
MEDICAL CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. SOUTHEAST ALABAMA MEDICAL CENTER, ITS AFFILIATES, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that my treatment or payment for services will not be denied if I do not sign this authorization unless specified on the other side of this form under Purpose of Request. I can inspect or receive a copy of the protected health information to be used or disclosed. I understand that there may be a charge for copies.
I authorize SOUTHEAST ALABAMA MEDICAL CENTER to use and disclose the protected health information specified on the other side of this form.

George H. Rhodes, Jr. — Signature of Patient or Personal Representative

5-10-06 — Date

Relationship if not patient: (Guardian/Executor of Estate/Personal Representative)

Day time phone number

Witness: M Nguerra, M

For Southeast Alabama Medical Center Use Only:

Patient's Medical Record #_____ Account #_____

Check Records Received by Patient:

☐ Complete health record	☐ Face Sheet	☐ X-ray films / Images
☐ Complete billing record	☐ History and physical exam	☐ X-ray reports
☐ Consultation reports	☐ Itemized bill	☐ _____
☐ Discharge summary	☐ Laboratory test results	☐ _____
☐ Emergency Dept. Reports	☐ Pathology Report	☐ _____

☐ OTHER _____

TOTAL PAGES SENT/GIVEN:_____

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify _____

Verified by: _____

TELEPHONE FOR MEDICAL RECORDS: (334) 793-8804

SOUTHEAST ALABAMA MEDICAL CENTER
P. O. BOX 6987

Whatever you do, do it well.™

www.samc.org

FACSIMILE COVER SHEET

To: Houston County Jail Medical Clinic

Fax: 671-9482

From: Release of Information
Dot Thompson

Fax: (334) 712-3509 or (334) 793-8863

Phone: (334) 699-4392

Re: Rhodes, George

Date: 5-1-06

Time:

Number of pages (including cover sheet): 4

Message: MRI Report not ready yet
DT

IMPORTANT NOTICE

This message is intended only for the use of the individual or entity to which it is addressed. It may contain information that is privileged, confidential and exempt from disclosure under law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the message to us, via the U.S. Postal Service, at the address below.

1108 ROSS CLARK CIRCLE, DOTHAN, AL 36301-3066
P.O. BOX 6987, DOTHAN, AL 36302-6987

2.764193

641

Sgt Sapper 4-23-06

HOUSTON COUNTY JAIL
INFIRMARY
901 EAST MAIN STREET
DOTHAN, ALABAMA 36301

SECTION 1 TO BE COMPLETED BY CORRECTIONAL FACILITY

Inmate referred to : (Name & Address)	Reason for referral:
SAMC - outpatient admitting for "MRI"	Md ordered

Appointment Date	Appointment Time	Date of Birth	Social Security #
4/28/06	645 AM	4/6/65	136-60-1743

Friday

Inmates Name: Rhodes George M

Additional Health Info. : MRI of (R) upper femur

Reason for Referral :

Deputy Required yes ( ) No (X) Ambulance Required Yes ( ) No (X

Nurse : V.O. per Dr. Barnes Grace Mathison RN or LPN

SECTION 2 TO BE COMPLETED BY INMATE

I authorize release of medical information to the Houston County Sheriff's Department.

[redacted] Date : 4-28-06

Dorothy Neal LPN

SECTION 3 TO BE COMPLETED BY PROVIDER

( ) Treated ( ) Further follow -up needed ( ) REFER for another Treatment or Test

DIAGNOSIS:	TREATMENT :

SIGNATURE OF PROVIDER DATE

CLINIC DIRECTOR :
D. Speigner CRNP

Telephones : (334) 712-0762 ext. 120 or 122
Sheriff's Office (334) 677- 4888

1st Shift

3rd Shift

Friday 4/28/06 645 AM

Sgt Turner 5-2-06

HOUSTON COUNTY JAIL
INFIRMARY
901 EAST MAIN STREET
DOTHAN, ALABAMA 36301

SECTION 1 TO BE COMPLETED BY CORRECTIONAL FACILITY

Inmate referred to : (Name & Address)		Reason for referral:	
SAMC - Outpatient admitting for "MRI"		Md order	
Appointment Date: 5-10-06	Appointment Time: 930AM	Date of Birth: 4/6/65	Social Security #: 136-60-1743
Inmates Name: Rhodes George		Additional Health Info. :	

Reason for Referral :

Deputy Required yes ( ) No (X) **Ambulance Required** Yes ( ) No (X)

Nurse : RN or L. Loguerro LPN

SECTION 2 TO BE COMPLETED BY INMATE

I authorize release of medical information to the Houston County Sheriff's Department.

Signature of Inmate Date :

SECTION 3 TO BE COMPLETED BY PROVIDER

( ) Treated ( ) Further follow -up needed ( ) REFER for another Treatment or Test

DIAGNOSIS:	TREATMENT :

Houston County Jail Medical Clinic
901 East Main Street
Dothan, Alabama 36301

Fax Transmittal

Phone: (334) 712-0762
Fax: (334) 671-9482

Lamar Glover, Sheriff

Dr. Sam Banner, Medical Director

Darla Speigner CRNP, Clinical Director

To: SAMC

Dr:

Department: Medical Records

Inmate Name:	DOB	SS#
Rhodes, George	4/6/65	136-60-1743

Please Send The Requested:

- ☐ Medical Records
- ☐ Medical Diagnosis
- ☐ Other
- ☐ Medical Administration Record
- ☐ X-ray Reports
- ☐ Specified Dates

Thanks for your Cooperation

Houston County Nursing Department

Faxed 4/28/06

Southeast Alabama
MEDICAL CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: Rhodes, George Date of Birth: 4/6/65

Address: _____

Social Security #: 136-60-1743 Telephone: _____

Information To Be Released - Covering the Periods of Health Care

From (date) 4/25/06 to (date) present

From (date) _____ to (date) _____

Please check type of information to be released:

- ☐ Complete health record
- ☐ Complete billing record
- ☐ Consultation reports
- ☐ Discharge summary
- ☐ Emergency Dept. Reports
- ☐ Face Sheet
- ☐ History and physical exam
- ☐ Itemized bill
- ☐ Laboratory test results
- ☐ Pathology Report
- ☐ X-ray films / images
- ☒ X-ray reports MRI results
- ☐ _____
- ☐ _____
- ☐ Other, (specify) _____

Purpose of Request

☒ Treatment or consultation ☐ At the request of the patient ☐ Billing or claims payment

☐ Other, (specify) _____

Who and Where to Send / Release Information

Name: _____

Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Circle One: (Yes) No

I understand if my medical or billing records or psychotherapy notes contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.

Circle One: (Yes) No

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Continued

Southeast Alabama
MEDICAL CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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I authorize SOUTHEAST ALABAMA MEDICAL CENTER to use and disclose the protected health information specified on the other side of this form.

* George W. Rhodes Jr. 4/28/06
Signature of Patient or Personal Representative — Date

Relationship if not patient: (Guardian/Executor of Estate/Personal Representative) — Day time phone number

Witness:

For Southeast Alabama Medical Center Use Only:

Patient's Medical Record #_____ Account #_____

Check Records Received by Patient:

☐ Complete health record	☐ Face Sheet	☐ X-ray films / images
☐ Complete billing record	☐ History and physical exam	☐ X-ray reports
☐ Consultation reports	☐ Itemized bill	☐ _____
☐ Discharge summary	☐ Laboratory test results	☐ _____
☐ Emergency Dept. Reports	☐ Pathology Report	☐ _____

☐ OTHER _____

TOTAL PAGES SENT/GIVEN:_____

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify _____

Verified by:_____

TELEPHONE FOR MEDICAL RECORDS: (334) 793-8001

SOUTHEAST ALABAMA MEDICAL CENTER
P. O. BOX 8087

FACSIMILE
COVER SHEET

Whatever you do, do it well.™

www.samc.org

To: HOUSTON CO JAIL

Fax: 96719482

From: VGRAYSON

Phone 334-793-8864

Pages: 4 (including banner)

Comment -

Rhodes
Im George

1108 ROSS CLARK CIRCLE, DOTHAN, AL 36301-3088
P.O. BOX 6987, DOTHAN, AL 36302-6987

Southeast Alabama MEDICAL CENTER

OUTPATIENT REGISTRATION

MR #	ADMIT DATE	ADMIT TIME	ADMITTER	PT TYPE	PT #
400545	5/10/06	9:21	DASY	1	2777788

NAME	AGE	DOB	SEX	RACE	MARITAL STATUS
RHODES JR, GEORGE HENRY	041Y	4/06/65	M	B	S

ADDRESS	REL	SRC	AD.CAT	FC	SPECIAL HDL	MSV
HOUSTON CO JAIL	JW	1	MD	D		MED

CITY	STATE	ZIP	CLINICS	ROOM/BED
DOTHAN	AL	36301		

PHONE	PT SSN	ATTENDING DOCTOR
334 794-5424	136-60-4317	BANNER,SAM

MAIDEN NAME	REFERRING DOCTOR
	BANNER,SAM

ALLERGIES	DPA	LW	CITY
DRUG/FOOD/NLKA/NDM	NO POWER	NO POWER	HOUSTON,AL

NEAREST RELATIVE	EMPLOYER	EMERGENCY CONTACT
	SELF-EMPLOYED	
ADDRESS	ADDRESS	ADDRESS
	507 S USSERY ST	
CITY/STATE/ZIP	CITY/STATE/ZIP	CITY/STATE/ZIP
,	DOTHAN, AL 36301	,
PHONE / PT REL	PHONE	PHONE / PT REL
	334 794-5424	

GUARANTOR #	SSN	GUARANTOR EMPLOYER
6299441	000-00-0000	INMATE OF HOUSTON CTY

NAME	ADDRESS 1
HOUSTON COUNTY JAIL, INMATE	
ADDRESS	ADDRESS 2
901 EAST MAIN STREET	
CITY/STATE/ZIP	CITY/STATE/ZIP / DSCH
DOTHAN, AL 36301 17	,
PHONE / PT REL	PHONE / DAYS
334 712-0762 / FR	

PATIENT STATES:
MI/ABNORMAL XRAY

ADMITTING DIAGNOSIS:
MI/ABNORMAL XRAY

	NAME	GROUP #	POLICY #
INS#1:			
INS#2:			
INS#3:			

COMMENTS:
PREG BY COMP/050906/PT IS INMATE/JLO ACT/PT SIGNED FORMS BILL JAIL/SEE CNE/DP

SDC/EST COST $3769.50

PRINCIPAL & SECONDARY DIAGNOSIS	CODES
	DATE DICTATED
	D/S
PROCEDURES & OPERATIONS/DATES	H&P
	O.R.
	Cons

CONSULTATION WITH

PHYSICIAN SIGNATURE

SOUTHEAST ALABAMA MEDICAL CENTER
PO Drawer 6987, Dothan, AL 36302
334-793-8111
RADIOLOGY SERVICES
MRI REPORT

Patient Name: RHODES, GEORGE
XRAY/MR#: 000400545 Account #: 2777788 Room:MI- -
DOB: 04/06/1965 Age: 41 Pt Type: O
Order #: 00127777888379206 Accession #: 001000000154472
CDM: 3836172
Attending Physician: Sam Banner, MD
Ordering Physician: Sam Banner, MD
Referring Physician: Sam Banner, MD
Exam Requested: MRI LOW EXT WO/W RT
Exam Date: 05/10/2006
PROCEDURE: MR RIGHT FEMUR W/O AND W/GADOLINIUM
HISTORY: RIGHT HIP PAIN AND SWELLING SINCE 2/11/06. PATIENT FELL AND HURT RIGHT HIP ON 2/11/06.
COMPARISON: PLAIN RADIOGRAPHS 4/4/06
TECHNIQUE: PATIENT STUDIED WITH AXIAL, CORONAL AND SAGITTAL T1 AND STIR SEQUENCES. IN ADDITION POST GADOLINIUM FAT SUPPRESSED CORONAL AND AXIAL T1 WEIGHTED SEQUENCES PERFORMED.

FINDINGS:
There is a large mass-like area involving the right upper thigh which is slightly hyperintense to muscle on T1 and is markedly hyperintense on T2 and has internal areas of mixed signal. Associated with this is abnormal marrow signal in the region of the greater trochanter of the femur and extending slightly into the intertrochanteric area. Review of the plain x-ray from 4/4 shows some soft tissue calcification.
Following Gadolinium administration there is abnormal enhancement evident within the periphery of the soft tissue of the mass as well as some abnormal enhancement within the intertrochanteric portion of the femur itself.
Continued..
The mass-like area mainly is involving the area of the vastus lateralis but near the upper thigh is almost completely encircling the femoral shaft. Main considerations particularly given the history of pain the

Hugh Holloway, MD
{eop}

SOUTHEAST ALABAMA MEDICAL CENTER
PO Drawer 6987, Dothan, AL 36302
334-793-8111

abnormal soft tissue calcification and the appearance of the mass with the abnormal Gadolinium enhancement is that of some type of chondrosarcoma. Other considerations include osteogenic sarcoma or much less likely a stress fracture of the femur with associated myositis ossificans. Patient incidentally appears to have some small inguinal lymph nodes bilaterally.

IMPRESSION:

1) LARGE MASS MEASURING APPROXIMATELY 13 X 9 X 8.5cm WHICH HAS ASSOCIATED SURROUNDING EDEMA IN THE SOFT TISSUES OF THE THIGH AS WELL AS ABNORMAL MARROW SIGNAL IN THE GREATER TROCHANTERIC REGION OF THE FEMUR. THIS IS SUSPICIOUS FOR ENTITIES SUCH AS A CHONDROSARCOMA, OSTEOGENIC SARCOMA OR LESS LIKELY A MALIGNANT FIBRO-CYSTICOTOMY. STRESS INJURY TO THE FEMUR WITH ASSOCIATED MYOSITIS OSSIFICANS MIGHT POSSIBLY GIVE THIS APPEARANCE BUT IS FELT LESS LIKELY GIVEN THE MARKEDLY ABNORMAL ENHANCEMENT PATTERN IN THE PROXIMAL FEMUR.

Hugh Holloway, MD
DD: 5/10/2006 13:02 dm
DT: 5/10/2006 16:11 147847
Name: RHODES, GEORGE MR: 000400545
Hugh Holloway, MD
{eop}

FACSIMILE
COVER SHEET

Whatever you do, do it well.™

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To: HOUSTON CO JAIL

Fax: 96719482

From: DTHOMPSON

Phone 334-793-8864

Pages: 6 (including banner)

Comment - RECORDS NOT READY YET

1108 ROSS CLARK CIRCLE, DOTHAN, AL 36301-3088
P.O. BOX 6987, DOTHAN, AL 36302-6987

Southeast Alabama MEDICAL CENTER

OUTPATIENT REGISTRATION

MR #	ADMIT DATE	ADMIT TIME	ADMITTER	PT TYPE	PT #
400545	4/28/06	6:43	OPJH	1	2764193

NAME	AGE	DOB	SEX	RACE	MARITAL STATUS
RHODES JR, GEORGE HENRY	041Y	4/06/65	M	B	S

ADDRESS	REL	SRC	AD.CAT	FC	SPECIAL HDL	MSV
507 S USSERY ST	JW	1	MD	S		MED

CITY	STATE	ZIP	CLINICS	ROOM/BED
DOTHAN	AL	36301		

PHONE	PT SSN	ATTENDING DOCTOR
334 794-5424	136-60-4317	BANNER,SAM

MAIDEN NAME	REFERRING DOCTOR
	BANNER,SAM

ALLERGIES	DPA	LW	CITY
DRUG/FOOD/NLKA/NDM	NO POWER	NO POWER	HOUSTON,AL

NEAREST RELATIVE	EMPLOYER	EMERGENCY CONTACT
RHODES, LINDA	SELF-EMPLOYED	RHODES, LINDA
ADDRESS: 906 WILLIAMS AVE	ADDRESS: 507 S USSERY ST	ADDRESS: 906 WILLIAMS AVE
CITY/STATE/ZIP: DOTHAN, AL 36301	CITY/STATE/ZIP: DOTHAN, AL 36301	CITY/STATE/ZIP: DOTHAN, AL 36301
PHONE: 334 699-6325 PT REL: SO	PHONE: 334 794-5424	PHONE: 334 699-6325 PT REL: SO

GUARANTOR #	SSN	GUARANTOR EMPLOYER
6423197	136-60-4317	SELF-EMPLOYED

NAME	ADDRESS 1
RHODES JR, GEORGE HENRY	507 S USSERY ST
ADDRESS: 507 S USSERY ST	ADDRESS 2
CITY/STATE/ZIP: DOTHAN, AL 36301	CITY/STATE/ZIP: DOTHAN, AL 36301 — DSCH
PHONE: 334 794-5424 PT REL: PT	PHONE: 334 794-5424 — DAYS

PATIENT STATES:
MI/ABNORMAL XRAY

ADMITTING DIAGNOSIS:
MI/ABNORMAL XRAY

	NAME	GROUP #	POLICY #
INS#1: INMATES PRIVATE PAY	RHODES JR, GEORGE H		136604317
INS#2:			
INS#3:			

COMMENTS:
COMP PRE/041106/VERIFY/ML //REG ORDERS PT SIG JRH

PLS VERIFY THAT PT IS STILL IN CUSTODY HO CO JAIL/EST COST $1884.75/SRE

PRINCIPAL & SECONDARY DIAGNOSIS	CODES
	DATE DICTATED
	D/S
PROCEDURES & OPERATIONS/DATES	H&P
	O.R.
	Cons

CONSULTATION WITH

PHYSICIAN SIGNATURE

Southeast Alabama Medical Center P.O. Box 6987 Dothan, AL 36302 334-793-8111

PRINTED BY: SAMC DATE 5/3/2006

#2049 Rev. 05/02

Southeast Alabama
MEDICAL CENTER

RHODES JR, GEORGE HENRY
DRUG/FOOD/NLKA/NDM
400545 2764193
BANNER,SAM

CONDITION OF TREATMENT/FINANCIAL AGREEMENT

1. **NURSING CARE:**
If the patient's condition requires care beyond routine nursing care, it is agreed that this must be arranged by the patient or his representative, and the hospital is not responsible to provide other than routine nursing care.

2. **CONSENT FOR TREATMENT:**
This is authorization and consent for care and treatment. It is understood that while a patient is in this hospital, Inpatient or Outpatient, the patient will be under the general care of his/her physician and does hereby authorize and consent to all care and treatment administered by Southeast Alabama Medical Center and its authorized representatives and to any further examination, care and treatment which may be deemed advisable and/or appropriate by his/her physician or other physicians or by authorized representatives of Southeast Alabama Medical Center.

3. **PERSONAL VALUABLES:**
The hospital maintains a safe for safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any personal property unless deposited with the hospital for safekeeping. (Examples of personal property include dentures,jewelry, hearing aids, glasses, money/credit cards, prothesis devices, and articles of clothing, etc.)
_____ Initials

4. **RELEASE OF PROTECTED HEALTH INFORMATION (PHI):**
While receiving treatment at Southeast Alabama Medical Center, I choose NOT to have my Protected Health Information (PHI) released to any of the following:

- ☐ Published in the hospital directory (name & room number)
- ☐ Used in marketing activities (name & address)
- ☐ Used in fundraising activities (name & address)
- ☐ Released to clergy (name, room number & religious affilation)

_____ Initials

5. **CHAMPUS MESSAGE:**
I acknowledge having received a copy of "An Important Message from Champus" and "How to Request a Review" of the Notice of Noncoverage for Champus. _____ Initials

6. **STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO PROVIDER:**
The undersigned and/or patient certifies that the information given by him/her in applying for payment under Title XVII and/or XIX of the Social Security Act is correct. The undersigned and/or patient requests that payment of authorized benefits be made to patient or on his/her behalf to Southeast Alabama Medical Center, including physician or supplier services for any services furnished to him/her. The undersigned and/or patient authorizes any holder of medical or other information about the patient to release to the Centers for Medicare and Medicaid Services, The State of Alabama, Georgia, Florida or their intermediaries, carriers or agents any information needed to determine these benefits or benefits for related services. It is understood that the undersigned and/or patient is responsible to Southeast Alabama Medical Center for any health insurance deductibles and coinsurance.

Continued.....

Southeast Alabama
MEDICAL CENTER

RHODES JR, GEORGE HENRY
DRUG/FOOD/NLKA/NDM
400545 2764193
BANNER,SAM

CONDITION OF TREATMENT/FINANCIAL AGREEMENT

I acknowledge having received a copy of "An Important Message from Medicare" and "How to Request a Review" of the Notice of Noncoverage from Medicare. _____Initials

7. **FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS:**

The undersigned agree(s), whether signing as agent or as patient, that in consideration of services to be rendered to patient, the undersigned is obligated to pay for same in accordance with the regular rates and terms of the hospital; and that should the account be referred by the hospital to an attorney for collection, the undersigned shall pay reasonable attorneys fees, interest and all costs of collection. Further, the undersigned waives as to this debt all rights of exemption under the constitution and laws of Alabama or any other states as to personal property.

In the event the undersigned and/or patient is entitled to hospital benefits to any type whatsoever, arising out of any insurance or any other party liable to the patient, then the undersigned assigns such benefits to Southeast Alabama Medical Center and the Radiologists, Pathologists, Anesthesiologists, Cardiologists and/or other consulting Physicians for application to the patient's bill. The undersigned hereby authorizes and directs that all insurance benefits assigned shall be paid directly to the hospital and/or physician for the respective services rendered. The undersigned and/or patient agrees and understands that acceptance of insurance coverage is conditional until insurance pays and all charges not paid by insurance are the responsibility of the undersigned and/or patient. The undersigned and/or patient is responsible for the compliance with any pre-certification and/or other requirements of any insurance company or third party payor. The undersigned and/or patient is responsible for any difference not paid by insurance whether it be for type room used or the charge structure used by the insurance company or third party payor versus that of the hospital/medical provider. The undersigned and/or patient may have access to billing information which may contain PHI. GH Initials

8. I have received a copy of the Medical Center's Notice of Privacy Practices. GH Initials

9. I have received a copy of the Smoking Cessation Guidelines. _____ Initials

10. **The undersigned and/or patient certifies that he/she has read the foregoing and agrees and accepts same.**

A Copy Of This Document Is To Be Delivered To The Patient/Patient's Agent.

4/28/06
DATE OF SIGNING

WITNESS

George H. Rhodes, Jr.
PATIENT

PATIENTS AGENT OR REPRESENTATIVE — RELATIONSHIP TO PATIENT

George H. Rhodes, Jr.
POLICYHOLDER

POLICYHOLDER

#243 Rev. 11/05 (2/2)

HOUSTON COUNTY JAIL
MEDICAL CLINIC

SICK CALL

DARLA SPEIGNER CRNP **DR. SAM BANNER**

DATE: 4-11-06

INAMATE: Rhodes George **D.O.B.** 4-6-65 **I/M #** 57322

MAIN COMPLAINT:

ALLERGIES: NKDA **V/S:** 107/80 20 98.2 83 wt 167

Seen by Dr B.
discussed condition
will get MRI
recs for Dr B

Put all app on FS.
Thanks

V.O. D Speigner CRNP/[illegible]

PHYSICIAN ORDERS

(Blackmale)

INMATE: Rhoden, Shonge # 57322

Has medical note

DATE: 4/11/06

Please move to MST

H. Spiegner MD

Sgt. Reynolds
04-11-06

9-9-05
B/P ✓ 116/81

10-17-05 B/P ✓ 115/77

HOUSTON COUNTY JAIL
MEDICAL CLINIC

SICK CALL

DARLA SPEIGNER CRNP **DR. SAM BANNER**

DATE: 4-11-06

INAMATE: Rhodes George **D.O.B.** 4-6-65 **I/M #** 57322

MAIN COMPLAINT: _____

ALLERGIES: NKDA **V/S:** 107/80 20 98 2 83 wt 167

Seen by dr B.
discussed condition
will get MRI
(ocs for dr B

Put all Rx on F.S.
Thanks

PHYSICIAN ORDERS

INMATE Rhodes, George

DATE 4/11/06

(212) 939-1000

1. Fax for records from Harlem Hospital (started I/m on ASA - 1998)
2. Schedule MRI of (R) femur (area of calcification) 4/25/06 - u
3. Will move to ... (done)

1322... Msg c̄ our # + ext left to please call us + gave I/m's name/DOB + we're calling in reference to (98). -u

George DOB 4/6/65

PHYSICIAN ORDERS

INMATE Rhodes, ~~George D.~~ ~~Joel~~ HE4G930

DATE 4/5/06

S/P xray - widest calcification in soft tissue (R)

Plan - refer to Dr. Brown

D Spivey

HOUSTON COUNTY JAIL
INFIRMARY

SICK CALL

D. SPEIGNER CRNP DR. SAM BANNER

DATE 4-4-06

Inmate Rhodes, George D.O.B. 4-6-65 JMS# 57322

Chief Complaint Back pain Rel 132/90

Allergies [redacted] V/S 131/91 84 18 97.9

Wt: 165

C/o (R) thigh swollen c̄ pain @ night

onset: 2/11/06 - fell

O WNWD BM, NAD. pleasant. (R) ↑ thigh is swollen, ∅ tender, ∅ erythema

Has difficulty putting shoes on 2/t this?

A: edema (R) thigh

Plan: 1. Measure (R) thigh 61 cm & (L) thigh - 56 ¼ cm

4/4/06 — 2. Xray (R) thigh @ area of edema (↑ femur)

4/11/06 — 3. F/p ref next wk

D Speigner

4. Flexeril 10 mg po. ḡ hs x 30 d. √FS √cart √MAR √CS } ll

OK SB ll APR 06

HOUSTON COUNTY JAIL
INFIRMARY

SICK CALL

Faxed for Records on outpatient visit 4-4-06

D. SPEIGNER CRNP — DR. SAM BANNER

DATE 4-4-06

Inmate Rhodes, George D.O.B. 4-6-65 JMS 57322

Chief Complaint Back pain — Rec 132/90

Allergies [redacted] — V/S 131/91 84 18 97.9

Wt: 165

C/o (R) thigh swollen c pain @ night

onset! 2/11/06 - fell

O. WNWDDM, NAD. pleasant. (R) thigh is swollen, Ø tender. Ø erythe

Has difficulty putting shoes on 1/t this ?

A: edema (R) thigh

Plan: 1. Measure (R) thigh 61 cm + (L) thigh - 56 1/4 cm

2. Xray (R) thigh @ area of edema (↑ femur)

3. f/p next wk

D Speigner

4. Flexeril 10 mg po. hs x 30 d.

HOUSTON COUNTY JAIL
INFIRMARY

SICK CALL

D. SPEIGNER CRNP DR. SAM BANNER

DATE 2-22-06

Inmate Rhodes, George D.O.B. 4-6-65 IM# 57322

Chief Complaint _____

Allergies NKDA V/S 119/79 60 18 97.5 wt- 166

- I/m states he slipped in shower on 2/11/06 – caught himself c (L) hand, but hit (R) knee.

- This I/m NEVER complains – takes meds (been here x 10 mos). Very pleasant.
Some swelling (R) thigh noted when compared to (L)

- R/o muscle strain

- Flexeril 10mg po bid x 30 days
IBU 600mg po bid x 10 days then + 400mg po bid x 20 days.
↳ denies GI hx

PE
C.S.
MAE
Cart

T.D. D. Speigner CRNP/ L. Hagan

PHYSICIAN ORDERS

INMATE Rhoden, George

DATE 6/05

record review

Atenolol 25 mg p.o. q d
Baby ASA (81 mg) p.o. q d
} For angina / palpitations

√ EKG
√ CXR
√ CBC
√ UA/UC
w/

B/P q mo. i HR

D Speigner MD

---

ref 11/3/05 Please rev HR. 11/4/05 w

D Speigner MD

HR = 68 BPM

PHYSICIAN ORDERS

INMATE Rhodes Ebaye

DATE 5/5/06

Fax for records from Dr. Pinson dob I.S.S.O.S
Dr

Medications

	STOP DATE	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Atenolol 25mg po qday		8am																														
6/15/05	cont																															
ASA 81mg po qday		8am																														
6/15/05	cont																															
[illegible]	[illegible]	8am																														
1/4/06		4pm																														

ALLERGY: NKDA

DIAGNOSIS:

PHYSICIAN NAME: D.Spolgnet CRNP — PHYSICIAN PHONE NO.:

FACILITY NAME: HCJ — SECTION: M — ROOM NO.:

PATIENT NAME: Rhodes, George — PATIENT NO.: 57322

NURSE'S SIGNATURE	INITIAL	NURSE'S SIGNATURE	INITIAL

PHARMACY SUGGESTIONS/RECOMMENDATIONS DO NOT SUPERCEDE PHYSICIAN ORDERS

3/06

	STOP DATE	HOUR
Atenolol 25mg po qday 6/15/05	cont	5am
ASA 81mg po qday 6/15/05	cont	5am
Flexeril 10mg po bid x 30 days 2/22/06	3/24	5 a.m. 7 p.m..
IBU 600mg po bid X 10 days then... 2/22/06	3/4 p am	5 a.m. 7 p.m..
IBU 400mg po bid X 20 days (start 3/4/06)	3/24	5 a.m. 7 p.m..

1 2 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 28 29 30

ALLERGY	NKDA				
DIAGNOSIS					
PHYSICIAN NAME	D.Speigner CRNP		PHYSICIAN PHONE NO.		
FACILITY NAME	HCJ	SECTION	F	ROOM NO.	
PATIENT NAME	Rhodes, George		PATIENT NO.	57322	

NURSE'S SIGNATURE	INITIAL	NURSE'S SIGNATURE	INITIA
M. Smith	MS		
			TO
D Baxter	AD		

PHARMACY SUGGESTIONS/RECOMMENDATIONS DO NOT SUPERCEDE PHYSICIAN ORDERS

	STOP DATE	HOUR	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Atenolol 25mg po qday 6/15/05	cont	5am	
ASA 81mg po qday 6/15/05	cont	5am	

ALLERGY	NKDA				
DIAGNOSIS	HTN				
PHYSICIAN NAME	D.Speigner, CRNP		PHYSICIAN PHONE NO.		
FACILITY NAME	HCJ	SECTION	F	ROOM NO.	
PATIENT NAME	Rhodes, George		PATIENT NO.	57322	

NURSE'S SIGNATURE	INITIAL	NURSE'S SIGNATURE	INITIAL

PHARMACY SUGGESTIONS/RECOMMENDATIONS DO NOT SUPERCEDE PHYSICIAN ORDERS

	STOP DATE	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Atenolol 25mg po qday		5am																														
6/15/05	cont																															
ASA 81mg po qday		5am																														
6/15/05	cont																															

ALLERGY	NKDA				
DIAGNOSIS	HTN				
PHYSICIAN NAME	D.Speigner, CRNP		PHYSICIAN PHONE NO.		
FACILITY NAME	HCJ	SECTION	F	ROOM NO.	
PATIENT NAME	Rhodes, George		PATIENT NO.	57322	

NURSE'S SIGNATURE	INITIAL	NURSE'S SIGNATURE	INITIAL

PHARMACY SUGGESTIONS/RECOMMENDATIONS DO NOT SUPERCEDE PHYSICIAN ORDERS

	STOP DATE	HOUR	1	2	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	28	29	30
Atenolol 25mg po qday 6/15/05	cont	5am																												
ASA 81mg po qday 6/15/05	cont	5am																												

ALLERGY	NKDA				
DIAGNOSIS	HTN				
PHYSICIAN NAME	D.Speigner, CRNP		PHYSICIAN PHONE NO.		
FACILITY NAME	HCJ	SECTION	F	ROOM NO.	
PATIENT NAME	Rhodes, George		PATIENT NO.	57322	

NURSE'S SIGNATURE	INITIAL	NURSE'S SIGNATURE	INITIAL

PHARMACY SUGGESTIONS/RECOMMENDATIONS DO NOT SUPERCEDE PHYSICIAN ORDERS

	STOP DATE	HOUR	1	2	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	28	29	30	31
Atenolol 25mg po qday 6/15/05	cont	5am																												
ASA 81mg po qday 6/15/05	cont	5am																												

ALLERGY	NKDA			
DIAGNOSIS				
PHYSICIAN NAME	D.Speigner CRNP	PHYSICIAN PHONE NO.		
FACILITY NAME	HCJ	SECTION	F	ROOM NO.
PATIENT NAME	Rhodes, George	PATIENT NO.	57322	

NURSE'S SIGNATURE	INITIAL	NURSE'S SIGNATURE	INITIAL
L. Laguerre LPN	L	D. Hathaway	DH
C Rodriguez LPN	C		

PHARMACY SUGGESTIONS/RECOMMENDATIONS DO NOT SUPERCEDE PHYSICIAN ORDERS

	STOP DATE	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
6/05 Atenolol 25mg PO daily	cont	5am								→																							
6/05 ASA 81mg PO daily	cont	5am												→																			

ALLERGY	NKDA			
DIAGNOSIS	HTN			
PHYSICIAN NAME	D. Speigner	PHYSICIAN PHONE NO.		
FACILITY NAME	HCJ	SECTION	F	ROOM NO.
PATIENT NAME	Rhodes, George	PATIENT NO.	57327	

NURSE'S SIGNATURE	INITIAL	NURSE'S SIGNATURE	INITIAL
C Harvey LPN	CH		
L. Hagan	H		

PHARMACY SUGGESTIONS/RECOMMENDATIONS DO NOT SUPERCEDE PHYSICIAN ORDERS